

# **Implementation of the Minnesota Medical Cannabis Program**

**Task Force on the Therapeutic Use of  
Medical Cannabis**

***Report to the Minnesota Legislature 2015***

**February 2015**

## **Letter from the Co-Chairs (Foreword)**

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# Executive Summary

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# Introduction

A medical cannabis therapeutic use law, Minnesota Laws 2014, Ch.311 (the Act), was signed by Governor Mark Dayton on May 29, 2014 and became effective on May 30, 2014. The legislation was designed to enable patients with certain qualifying conditions to use medical cannabis for therapeutic treatment, while preventing it being misused or diverted from its medical purpose. Another aim of the program is to generate and collect data using science-based methods, to advance evidence of the efficacy of cannabis in treating specified medical conditions.

The Act created the Minnesota medical cannabis registry program and also created the Task Force on Medical Cannabis Therapeutic Research. This Task Force is charged with holding hearings to conduct impact assessments of medical cannabis program in Minnesota. The first report required of this Task Force is a report on the design and implementation of the registry program by February 1, 2015 (See Minnesota Statutes section 152.36, subdivision 4(a)(1)).

The Task Force has held \_\_ meetings. The first meeting was held on July 31, 2014. Full documentation of its work can be found on its website at <http://www.lcc.leg.mn/mctrtf>. A list of Task Force members can be found in Appendix A.

The Act placed the responsibility of implementation with the Minnesota Department of Health (“MDH” or “the Department”). Since the passage of the Act, MDH established an Office of Medical Cannabis (“OMC”). This document reports the status of the MDH’s progress in implementing Laws 2014 Ch. 311. This report provides an overview of the status of the Manufacturer registration, administrative rules, describes the development of the patient, caregiver, and health care practitioner registries; discusses communication and education efforts; explains the regulatory process; etc.

The launch period of any new program is critical. Early implementation decisions are also magnified. The way in which a program is initially designed and executed will shape its subsequent development. Implementation involves the design, construction, and execution of institutions, rules, and processes related to a system of medical cannabis. Some elements of the system are formal legal and regulatory actions; others may be informal efforts, such as outreach and coordination. Successful implementation includes meeting the enabling law’s requirements, but is not limited to that.

For state medical cannabis programs, implementation matters for other, unique reasons. First, state medical cannabis programs such as Minnesota’s raise uncomfortable federalism issues. Even though Minnesota Laws, Chapter 311 provides protections for medical cannabis patients and caregivers, health care practitioners, and medical cannabis manufacturers under state law for those who cultivate, produce, distribute, use and possess cannabis under the auspices of the program, those activities remain violations of numerous federal law and regulations, most notably the Controlled Substances Act of 1970. In response to the prevalence of state medical cannabis programs in the nation and the disconnect between state and federal law, the U.S. Department of Justice issued a memo in August 2013 (the “Cole memo”) that clarified federal

government priorities in this area. The memo says that the federal government expects states that “endeavor to authorize marijuana production, distribution, and possession” will “implement strong and effective regulatory and enforcement systems that will address the threat those state laws could pose to public safety, public health, and other law enforcement interests.”

Therefore, the federal government, in the context of Department of Justice enforcement, will take a hands-off approach to the enforcement of the Controlled Substances Act if and only if states implement regulation effectively and comprehensively. Less than effective implementation poses a risk that the federal government will step in, and shut down the medical cannabis program in the state.<sup>1</sup>

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<sup>1</sup> For example, in an interview with the Los Angeles Times, Deputy Attorney General James M. Cole warned the state of California that “If you don’t want us prosecuting [marijuana users] in your state, then get your regulatory act together.” “DOJ official: California should strengthen medical marijuana oversight,” Los Angeles Times, website article dated 10/16, 2014. Accessed at <http://www.latimes.com/local/lanow/la-me-ln-california-medical-marijuana-oversight-20141016-story.html> on November 20, 2014.

# Key Program Dates

## May 29, 2014

- Medical cannabis legislation, Minnesota Laws 2014, Chapter 311, is signed into law.

## July 10, 2014

- Members of task force on medical cannabis therapeutic research appointed by legislature and Governor.

## July 31, 2014

- First meeting of the task force on medical cannabis research.

## August 1, 2014

- Commissioner of Health determines there is not an adequate supply of federally sourced medical cannabis available and that there is a need for in-state manufacturing of medical cannabis for 2015.
- MDH releases an initial draft of manufacturer rules and the "Request for Applications" for public comment. The "Request for Applications" is the process by which potential manufacturers will apply to be selected for registration by MDH.

## August 8, 2014

- MDH hosts public meeting of individuals/groups interested in participating in medical cannabis manufacturing process. Over 230 attend.

## August 13, 2014

- Michelle Larson appointed director of OMC.

## September 5, 2014

- MDH releases request for applications to become a state-certified medical cannabis manufacturer.
- Official notice of expedited manufacturer rules released.

## September 19, 2014

- Letters of Intent to Apply due for manufacturers seeking registration.

## **October 3, 2014**

- Deadline for manufacturer applications.

## **November 1, 2014**

- Commissioner of Health informs public and medical cannabis task force that state will be able to register at least one manufacturer by December 1, 2014.

## **December 1, 2014**

- Commissioner of Health registers two in-state manufacturers for production of medical cannabis products in Minnesota.
- Commissioner of Health to issue Dosage and Composition report on:
  - Existing medical and scientific literature regarding the range of recommended dosages for each qualifying condition.
  - Range of chemical compositions of any plant of the genus cannabis that will likely be medically beneficial for each of the qualifying medical condition.

## **January 1, 2015**

- Deadline for Commissioner of Health to publish notice of proposed rules in State Register [for rules using expedited process only].

## **January 15, 2015**

- Deadline for the commissioners of state departments impacted by the medical cannabis therapeutic research study to report on the costs incurred by each department.

## **February 1, 2015**

- Deadline for Task Force to complete a report on the design and implementation of the registry program.

# Key Elements of Minnesota's Medical Cannabis Program Implementation

## Key Design Features.

**Office of Medical Cannabis.** Since the passage of the Act, the Department has established the Office of Medical Cannabis (“OMC”) under Assistant Commissioner for Strategic Initiatives, Manny Munson-Regala. Michelle Larson was named director of the new office on August 13, 2014. Dr. Tom Arneson began work as research director for OMC on October 6, 2014. The office is also staffing below leadership positions and currently has five full-time employees.

**Medical and Scientific Support.** Supporting evidence relating to the proper uses of medical cannabis is limited (in part due to the legal barriers to conducting such research). Therefore, one of the priorities of the program is data gathering. On December 1, 2014, the Department issued *“A Review of Medical Cannabis Studies relating to Chemical Compositions and Dosages for Qualifying Medical Conditions”* to satisfy a requirement set out in Minnesota Statutes section 152.25, subdivision 2. This report summarizes clinical trials and prospective observational studies in humans, published in peer-reviewed journals. The studies reviewed are not limited to studies conducted in the United States but they do focus on medical cannabis formulations consistent with Minnesota's medical cannabis program. Relevant new study publications and newly discovered existing study publications will be included as they come to the attention of the Office of Medical Cannabis in in periodic updates of the report.

The report focused on medical cannabis formulations consistent with Minnesota's medical cannabis program requirements and found relatively few relevant clinical trials, especially large clinical trials that can produce the most definitive results. However, the report points out that the number of clinical trials appears to be increasing in recent years.

During the late 1980's and early 1990's, a series of scientific breakthroughs revealed an in-built system of cannabinoid receptors and cannabinoid signaling molecules in the human brain. Cannabinoid receptors are located throughout the central nervous system and peripheral tissues and are implicated in nervous system excitability, movement, analgesia, and neuroprotection. Following this period of scientific discovery and expanded understanding of the physiological basis of cannabinoid action, there was renewed interest in potential therapeutic applications of cannabinoid chemicals. Additional research is still needed to ascertain cannabis's general medical safety, therapeutic properties and to determine standard and optimal doses and routes of delivery.

**Structure of the Program.** There are two key structural design features of the Minnesota medical cannabis program. First, there are two manufacturers responsible for the cultivation,

production, and distribution of medical cannabis within the state. Second, there is a medical cannabis patient registry. In order to achieve implementation and avoid delays, the legislature established strict deadlines in the enabling legislation to force the speedy implementation of the program. For example, Minnesota Statutes section 152.26 authorizes the Department to publish rules using the expedited rulemaking process only until January 1 2015.

The legislation legalized the regulated production, possession, delivery and use of cannabis for medical purposes. It creates a system governing the production and distribution of medical cannabis and the certification and registration of patients and their caregivers. Organizations that are registered by the Department to cultivate and dispense medical cannabis must undergo a stringent vetting process. In particular, among other criteria established in RFA, the criteria used to select registered manufacturers included those listed in Minnesota Statutes sections 152.25, subdivision 1(c): technical expertise, employee qualifications, financial stability ability to provide appropriate security and projected patient fees. Manufacturer registrations are to be renewed annually and continual reporting to the Department is required.

The Act also defines the population which may be granted permission for medical use and the circumstances governing such permission. Certified patients and their designated caregivers are registered with the Department and are only allowed to possess a limited amount of cannabis for use at a given time. Patients certified to use medical cannabis must be under the care of a specified licensed practitioner. It also provides an opportunity for the accumulation of relevant data for further evaluation of the program's efficacy. All aspects of the system are to be substantially regulated by the Department.

# Minnesota Medical Cannabis Program

## Manufacturer evaluation and selection

Section 5 of the Act requires the Department to register by December 1, 2014 two vertically integrated medical cannabis manufacturers to produce medical cannabis to distribute to patients who qualify for the program.<sup>2</sup> The Department pursued a comprehensive and impartial evaluation and selection process for deciding on the two medical cannabis manufacturers that have been registered.

To satisfy the Act's requirement that the 8 distribution facilities of the manufacturers permitted by the Act be located based on geographical need,<sup>3</sup> the Department has required there will be one medical cannabis distribution site in each of Minnesota's eight congressional districts; one manufacturer will have a distribution site in each of the even number congressional districts, and the other manufacturer will have a distribution site in each of the odd numbered congressional districts. The congressional district siting method was selected to ensure geographical spread. Each manufacturer must have one medical cannabis distribution site operational by July 1, 2015 and all four distribution sites operational by July 1, 2016.

The medical cannabis manufacturer evaluation process occurred over the following timeline:

- Manufacturer Interested Parties Conference – August 8, 2014
- Request for Applications (RFA) Published – September 5, 2014
- Intent to Apply Due Date – September 19, 2014
- Application Due Date – October 3, 2014
- Application Evaluation
  - Completeness review and pass/fail criteria evaluation
  - Review of applications
  - Scoring of applications
- Prospective Manufacturer Presentations – October 27 – 30, 2014
- Identification of Semi-finalists – November 3, 2014
- Semi-finalist Site Visits – November 10 – 18, 2014
- Selection of 2 Finalists – November 24, 2014
- 2 Manufacturers Registered – December 1, 2014

On August 8, 2014, the Department held an Interested Parties meeting for anyone who was interested in learning more about becoming a medical cannabis manufacturer in Minnesota. Over 230 parties attended the public meeting which was held at the Minnesota History Center.

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<sup>2</sup> See Minnesota Statutes section 152.25, subdivision 1(a).

<sup>3</sup> Minnesota Statutes, section 152.29, subdivision 1.

On September 5, 2014, the Department issued a Request for Applications (RFA), inviting parties interested to prepare applications. As part of the RFA process, potentially interested parties were required to file an “intent to apply” letter by Sept. 19, 2014. The Department received 29 letters of intent, more than anticipated.

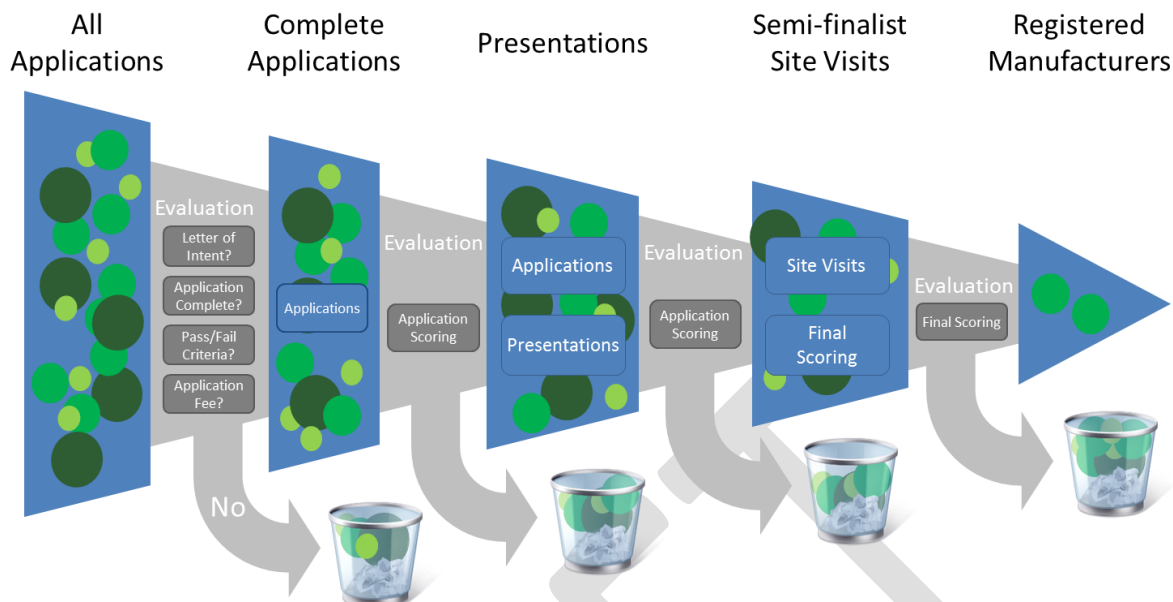
On October 3, 2014, MDH received 12 applications accompanied by a non-refundable \$20,000 application fee. MDH then began the evaluation and review process, creating an applicant selection panel to assist in the scoring of the applications received. This panel worked in sub-teams to focus their expertise on defined areas of the application and then the panel convened as a whole to receive reports from the sub-teams. The Review Panel then scored the applications.

Manufacturer applicants were given the opportunity to further inform the applicant selection panel about the applicant’s organization and operations as well as provide the opportunity for the panel the opportunity to ask questions of the applicants during the week of October 27, 2014. These presentations were not open to the public.

MDH leadership then conducted site visits to operations runs by four finalist. Following this, MDH selected and registered the two highest rated manufacturer applicants on December 1, 2014. These manufacturers are <MANUFA> and <MANUFB>. <MANUFA> has been registered to serve even-numbered congressional districts and <MANUFB> will serve odd-numbered congressional districts within the state. <MANUFA>’s manufacturing site will be locate in the city of \_\_\_\_\_, Minnesota and <MANUFB> has indicated that its manufacturing center will be located in \_\_\_\_\_, Minnesota.

Under the terms of the statute, manufacturers are required to be ready to distribute medical and have at least one distribution site open by July 1, 2015. As noted above, each of the two manufactures will have four operational distribution sites within the state by July 1, 2016.

Below is a graphical depiction of the process and the points in the process when some applicants were eliminated from consideration.



**Assessment and evaluation.** The Department registered two medical cannabis manufacturers within six months of the enabling legislation's effective date. The process used to select these manufacturers was fair, thorough and intense.

# Patient Registry

Minnesota Statutes section 152.27, subdivision 1 provides that the Department will establish a medical cannabis therapeutic use patient registry. Any Minnesota resident with a qualifying medical condition may be entered into the patient registry. The patient registration fee is \$200 and is valid for one year. Patients who receive SSI/SSD receive a reduced registration fee of \$50. Section 152.22, subdivision 14 defines the term "qualifying medical condition" as:

1. Cancer, if the underlying condition or treatment produces one of more of the following:
  - a) Severe or chronic pain; or
  - b) Nausea or severe vomiting; or
  - c) Cachexia or severe wasting;
2. Glaucoma;
3. Human immunodeficiency virus or acquired immune deficiency syndrome;
4. Tourette's syndrome;
5. Amyotrophic lateral sclerosis;
6. Seizures, including those characteristic of epilepsy;
7. Severe and persistent muscle spasms, including those characteristic of multiple sclerosis;
8. Crohn's disease;
9. Terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:
  - a) Severe or chronic pain; or
  - b) Nausea or severe vomiting; or
  - c) Cachexia or severe wasting;
10. Any other medical condition or its treatment approved by the commissioner.

The Act requires the commissioner of health to consider adding Intractable Pain before adding any other condition to the list of qualifying conditions.

In order to qualify as a patient under the program, a person must have written certification from a health care practitioner, affirming that the person has been diagnosed with a qualifying medical condition. A health care practitioner is defined as a medical doctor, physician's assistant, or advanced practice registered nurse licensed in Minnesota. Minnesota Statutes section 152.28, subdivision 1, requires a certifying health care practitioner to, among other things:

- (1) Determine whether the patient suffers from one of the qualifying medical conditions;
- (2) determine whether the patient is requires a designated caregiver due to developmental or physical disability; and
- (3) agree to continue treating the patient's medical condition and report medical findings to the Department.

Health care practitioner participation in the registry program is voluntary. MDH is currently developing educational materials for health care practitioner training.

MDH estimates beginning taking applications on or around June 1, 2015 and is expecting 5,000 applicants in the first year, although that estimate is very rough.

Design of the Minnesota Patient Registry Program:

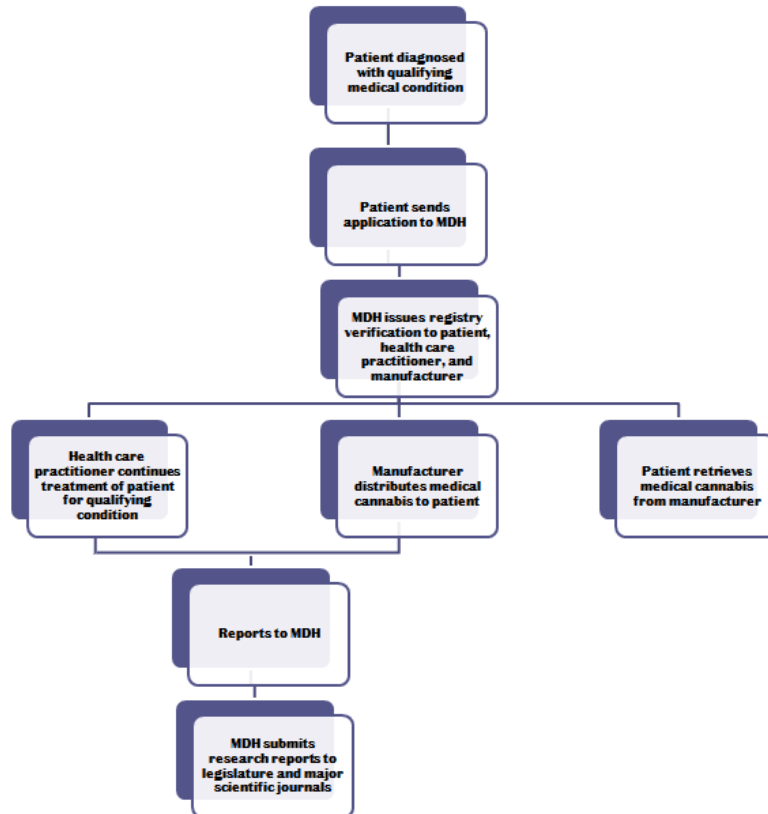


Figure 1: source: Minnesota House Research

**I.T. Registry.** The Department has contracted with MN.IT for the development of an electronic patient and caregiver registration and payment process. The registration and payment process will be through an encrypted web application that provides security of personal, medical and financial information of the applicant. The platform is also being designed to allow MDH the ability to gather and evaluate data on patient demographics, effective treatment options, clinical outcomes, and quality of life outcomes. Although this work could be done manually, it would require a significant increase in staffing and cost. In addition, absent a functioning IT platform, there will be an increase in difficulty obtaining and analyzing patient data.

**Assessment and evaluation.** The Department has taken steps to enable the patient registry program be available before the statutory target date of July 1, 2015.

# Administrative Rulemaking

The Department was given the authority to adopt and implement administrative rules using the expedited rulemaking process under Minnesota Statutes, section 14.389. 2014 Minnesota Laws, chapter 311, section 5, subdivision 3 (codified at Minnesota Statutes, section 152.25, subdivision 3(a)), provides:

The commissioner shall adopt rules necessary for the manufacturer to begin distribution of medical cannabis to patients under the registry program by July 1, 2015, and have notice of proposed rules published in the State Register before January 1, 2015.

and in 2014 Minnesota Laws, chapter 311, section 6 (codified at Minnesota Statutes, section 152.26), provides:

The commissioner may adopt rules to implement sections 152.22 to 152.37. Rules for which notice is published in the State Register before January 1, 2015, may be adopted using the process in section 14.389.

Therefore, the commissioner is authorized to use the expedited rulemaking process to adopt and implement rules necessary for medical cannabis manufacturers to begin distributing medical cannabis to patients.

**Manufacturer Rules.** MDH published in the State Register proposed rules applicable to medical cannabis manufacturers on Oct 6, 2014, which will become effective in <DATE>.

These expedited rules govern those responsibilities and prescribe the manufacturers' operation. They spell out restrictions for producing medical cannabis starting with planting, growing, and harvesting cannabis plants through processing them into medical cannabis. These rules also specify how the manufacturers must handle the medical cannabis until it is dispensed. The manufacturers' requirements address:

- Packaging and labeling the medical cannabis for patients,
- Site security,
- Transportation and its corresponding security,
- Advertising and marketing the manufactured medical cannabis,
- Disposing cannabis plant material and waste medical cannabis,
- Quality assurance of the medical cannabis produced, and

- Record keeping.

In addition to the manufacturers' operation requirements, the proposed rules describe how the commissioner will administer the following oversight functions:

- Manufacturer registration,
- Facility inspection,
- Testing labs approval
- Registration revocation, and
- Voluntary facility closure.

**Patient and Health Care Practitioner Rules.** MDH published proposed rules applicable to medical cannabis patients and health care practitioners on December 15, 2014, which will become effective <DATE>.

These proposed expedited rules establish requirements for patients, caregivers, and healthcare practitioners taking part in the registry and also processes addressing how to request the addition of qualifying medical conditions or delivery methods. The patient registry requirements explain:

- Application qualifications and procedures for patients, designated caregivers, and health care practitioners.
- Procedure for health care practitioners providing a written certification of a patient's qualifying medical condition.
- Prohibitions for health care practitioners,
- Revocation or suspension of a qualifying patient or designated caregiver registration,
- Record keeping and reporting requirements for health care practitioners.

In addition to the operational requirements of the patient registry, the proposed rules describe the following functions:

- Procedure for requesting a medical condition or delivery method be added to the list of qualifying medical conditions
- Procedure for requesting a delivery method be added to the list of approved delivery methods,,
- Medical cannabis point-of-distribution requirements, including dosage calculation and purchasing limits,
- Reporting requirements for serious health effects and unauthorized possession incidents.
- Disposal of unused medical cannabis by persons authorized to possess it.

**Formal Rulemaking.** A third rulemaking process, following the formal rulemaking process found in Minnesota Statutes chapter 14, has begun and involves a stakeholder advisory

committee comprised of members representing the following stakeholder groups:  
\_\_\_\_\_. The Advisory Committee began meeting in January 2015.

**Assessment and evaluation.** The Department has taken advantage of its expedited rulemaking authority given in Minnesota Statutes section 152.26 to propose administrative rules in order to implement the program by July 1, 2015. It has met all statutory deadlines and is still involved in the formal rulemaking. Running two expedited rulemaking processes in parallel with strict deadlines, while still in program start-up mode has put at risk a certain amount of public involvement and deliberation. The formal rulemaking process will allow for a more deliberative review of the rules adopted in the expedited processes and also provide a limited opportunity to modify the rules adopted following the expedited process in response to new legislative requirements coming from the 2015 legislative session.

# Medical Cannabis in Other States

Currently, 23 states and the District of Columbia have medical cannabis programs: Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, and Washington. Minnesota has been able to draw on the experience of other states during the early stages of implementation of its program.

There are some program characteristics that all or nearly all of the states with medical cannabis programs have addressed in one fashion or another. The approach used to address these issues depends upon a number of factors, including qualifying medical conditions, allowable forms of medical cannabis, approved delivery methods, the size of their medical cannabis patient population, the distribution of population within the state, support for the program among key stakeholder groups and among its decision-makers, what is politically feasible at the time the program is established, and other state-specific factors. Each state's program remains a creature of its own particular situation..

All these state laws allow patients to use and possess small amounts of cannabis for medical purposes without being subject to state criminal penalties. Some of these programs are relatively new, and the programs, or aspects of the program such as the distribution systems, are not yet operational. For example, while eighteen states provide for distribution systems, only eight [or 9] states (Arizona, California, Colorado, Maine, [Massachusetts?] New Jersey, New Mexico, Rhode Island, and Vermont) have operational distribution systems. Also, many of the earlier states to adopt medical cannabis programs did not provide for distribution systems. Thus only a few states have much of a track record concerning a programmatic medical cannabis distribution system and related issues such as cultivation, access, security, and transportation.

In addition to the twenty-three states with medical cannabis programs, eleven other states have recently enacted limited access cannabis product laws that make provision for the use of certain strains of cannabis for limited medical or research purposes. While not as comprehensive as Minnesota's medical cannabis program, these limited access laws have focus on strains of cannabis that have little or no psychoactive effects. As a result, an increasing number of states have shown interest in pursuing similar laws.

## Table

States with medical cannabis programs

States with limited access marijuana product laws (lowTHC/High CBD)

<http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx>

# Federal

## **Federal Position on the Medical Use of Marijuana**

### *Controlled Substances Act*

The fact that cannabis is a Schedule I controlled substance under federal law complicates the implementation of the Act. The Controlled Substances Act, enacted by the United States Congress in 1970, is the basis for federal drug policy under which the manufacture, use, possession, and distribution of certain substances is regulated. The Controlled Substances Act classifies cannabis as a Schedule I substance, which does not permit the use of cannabis for any purpose, whether medical or nonmedical, and allows for very limited research protocols only.

The U.S. Drug Enforcement Agency (“DEA”) is responsible for scheduling controlled substances, that is, drugs and other agents that possess a potential for abuse. Under the Controlled Substances Act, the DEA places each drug that has abuse potential into one of five categories. The five categories, referred to as Schedules I—V, carry different degrees of restriction. Schedule I is the most restrictive, covering drugs that have "no accepted medical use" in the United States and that have high abuse potential. Each schedule is associated with a distinct set of controls that affect manufacturers, investigators, pharmacists, practitioners, patients, and recreational users.

Under the Controlled Substances Act, cannabis is in Schedule I, the most restrictive schedule. The scheduling of any other cannabinoid under this act depends on whether it is found in the plant. All cannabinoids in the plant are automatically in Schedule I because they fall under the act's definition of cannabis.<sup>4</sup> In addition, under DEA's regulations, synthetic equivalents of the substances contained in the plant and "synthetic substances, derivatives, and their isomers" whose "chemical structure and pharmacological activity" are "similar" to THC also are automatically in Schedule I.<sup>5</sup>

Researchers are affected by Schedule I requirements even if their research does not involve human subjects. For example, researchers studying cannabinoids found in the plant are required under the Controlled Substances Act to submit their research protocol to DEA, which issues a registration that is contingent upon the approval of the protocol by the U.S. FDA.<sup>6</sup> DEA also inspects the researcher's security arrangements.

*Does the Task Force Want to Make a Statement Regarding Rescheduling?*

### *United States Department of Justice Guidelines*

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<sup>4</sup> 21 U.S.C. § 802 (16).

<sup>5</sup> 21 CFR § 1308.11(d)(27).

<sup>6</sup> 21 CFR § 1301.18

On October 19, 2009, the United States Department of Justice issued a memorandum (“the Ogden Memorandum”) that advised federal prosecutors in states with medical cannabis programs to refrain from pursuing cases against individuals for marijuana offenses that did not violate state medical cannabis laws.

In a subsequent memorandum issued on August 29, 2013 (“the Cole Memorandum”), the Department of Justice clarified its position on cannabis by listing specific nationwide enforcement priorities and noted that it has not historically devoted resources to prosecuting individuals whose conduct is limited to possession of small amounts of cannabis for personal use on private property and that it has generally left enforcement to state and local authorities unless the cannabis-related activities run afoul of the listed enforcement priorities identified in the memo.

The Department of Justice indicated that it will defer to state and local enforcement in states that authorize the production, distribution, and possession of medical cannabis, provided the affected states implement strong and effective regulatory and enforcement systems that will address the threat those state laws could pose to public safety, public health, and other law enforcement interests. However, the 2013 memorandum also warned that states that enact cannabis legalization schemes but fail to implement them effectively could be subject to federal intervention.

#### *United States Department of the Treasury Guidelines*

Cannabis-related businesses have complained that federal cannabis prohibitions, combined with federal requirements regarding financial institutions, block their access to banking and credit card services and limit them to cash transactions that raise security concerns. Banks have also raised concerns that providing services to cannabis-related businesses could subject them to federal penalties. These combined concerns resulted in medical cannabis related businesses being unable to deposit revenues from their businesses into financial institutions.

Given these concerns, the United States Department of the Treasury issued a memorandum on February 14, 2014, to clarify Bank Secrecy Act expectations for financial institutions, such as banks, that seek to provide services to medical cannabis-related businesses.

The Treasury memorandum establishes guidelines to clarify and streamline federally required reporting requirements for financial institutions seeking to provide financial services to medical marijuana-related businesses. The Treasury memorandum provides guidance on how to indicate whether or not the marijuana-related business raises suspicion of any illegal activity, other than a violation of the federal prohibitions against cannabis, or any activity that implicates any of the Department of Justice's enforcement priorities regarding cannabis.

# Conclusion/Summary

*Insert Conclusions Here*

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## **Appendix 1: Task Force on Medical Cannabis Therapeutic Research**

<b>Task Force Members</b>	<b>Appointed By</b>
James Backstrom	Governor
Duane Bandel	Governor
Maria Botker	Governor
Senator D. Scott Dibble	Senate Majority Leader
Ramona Dohman, Commissioner of Public Safety	
Dr. Edward Ehlinger, Commissioner of Health	
Dennis Flaherty	Governor
Karina Forrest-Perkins	Governor
James Franklin	Governor
Representative Patrick Garofalo	House Minority Leader
Dr. Pamela Gonzalez	Governor
David Hartford	Governor
Vincent Hayden, PhD	Governor
Lucinda Jesson, Commissioner of Human Services	
David Kolb	Governor
Representative Carly Melin	Speaker of The House
Doreen McIntyre	Governor
Senator Branden Petersen	Senate Minority Leader
Jeremy Pauling	Governor
Dr. Charles Reznikoff	Governor
Laura Schwartzwald	Governor
Sarah Wellington	Governor
Dr. Dawn Wyllie	Governor

## Appendix 2. States with Medical Cannabis Programs

State with Medical Cannabis Program	Statutory Language (year)
<b>Alaska</b>	Measure 8 (1998) SB 94 (1999) Statute Title 17, Chapter 37
<b>Arizona</b>	Proposition 203 (2010)
<b>California</b>	Proposition 215 (1996) SB 420 (2003)
<b>Colorado</b> Medical program info	Amendment 20 (2000)
<b>Connecticut</b>	HB 5387 (2012)
<b>Delaware</b>	SB 17 (2011)
<b>District of Columbia</b>	Initiative 59 (1998) L18-0210 (2010)
<b>Hawaii</b>	SB 862 (2000)
<b>Illinois</b>	HB 1 (2013) <i>Eff. 1/1/2014</i> Proposed rules as of April, 2014
<b>Maine</b>	Question 2 (1999) LD 611 (2002) Question 5 (2009) LD 1811 (2010) LD 1296 (2011)
<b>Maryland</b>	HB 702 (2003) SB 308 (2011) HB 180/SB 580 (2013) HB 1101- Chapter 403 (2013) SB 923 (signed 4/14/14) HB 881- similar to SB 923
<b>Massachusetts</b>	Question 3 (2012) Regulations (2013)
<b>Michigan</b>	Proposal 1 (2008)
<b>Minnesota</b>	SF 2471, Chapter 311 (2014)
<b>Montana</b>	Initiative 148 (2004) SB 423 (2011)
<b>Nevada</b>	Question 9 (2000) NRS 453A NAC 453A
<b>New Hampshire</b>	HB 573 (2013)
<b>New Jersey</b>	SB 119 (2009) Program information
<b>New Mexico</b>	SB 523 (2007) Medical Cannabis Program

State with Medical Cannabis Program	Statutory Language (year)
<b>New York</b>	A6357 (2014) Signed by governor 7/5/14
<b>Oregon</b>	Oregon Medical Marijuana Act (1998) SB 161 (2007)
<b>Rhode Island</b>	SB 791 (2007) SB 185 (2009)
<b>Vermont</b>	SB 76 (2004) SB 7 (2007) SB 17 (2011)
<b>Washington</b>	Initiative 692(1998) SB 5798 (2010) SB 5073 (2011)

Source: <http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx>

State with limited access law (low THC/High CBD Program)	Program Name and Statutory Language (year)
<b>Alabama</b>	SB 174 "Carly's Law" (Act 2014-277) Allows University of Alabama Birmingham to conduct effectiveness research using low-THC products for treating seizure disorders for up to 5 years.
<b>Florida</b>	Compassionate Medical Cannabis Act of 2014 CS for SB 1030 (2014)  Patient treatment information and outcomes will be collected and used for intractable childhood epilepsy research
<b>Iowa</b>	SF 2360, Medical Cannabidiol Act of 2014 (Effective 7/1/14)
<b>Kentucky</b>	SB 124 (2014) Clara Madeline Gilliam Act  Exempt cannabidiol from the definition of marijuana and allows it to be administered by a public university or school of medicine in Kentucky for clinical trial or expanded access program approved by the FDA.

State with limited access law (low THC/High CBD Program)		Program Name and Statutory Language (year)
Mississippi		HB 1231 "Harper Grace's Law" 2014
Missouri		HB 2238 (2014)
North Carolina		HB 1220 (2014) Epilepsy Alternative Treatment Act- Pilot Study
South Carolina		SB 1035 (2014) Medical Cannabis Therapeutic Treatment Act- Julian's Law
Tennessee		SB 2531(2014) Creates a four-year study of high CBD/low THC marijuana at TN Tech Univ.
Utah		HB 105 (2014) Hemp Extract Registration Act
Wisconsin		AB 726 (2013 Act 267)

Source: <http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx>

**Appendix 2. Request for Applications from Medical Cannabis Manufacturers**

**Appendix 3. Manufacturers draft Rules**

**Appendix 4. Patient and Health Care Practitioner draft Rules.**

**Appendix 5. Press releases**

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